



**Health Net of the Northeast
Prescription Claim Reimbursement Form**

This claim form should be used by members to request reimbursement for covered medications. Submission of this form does not guarantee reimbursement. Please consult your plan documents for additional coverage information.

INSTRUCTIONS	MAILING ADDRESS
<ul style="list-style-type: none"> ➤ Please complete the member information below. You will find your Health Net member ID number on your membership identification card. ➤ Please attach your itemized pharmacy receipt(s). Unfortunately, we are not able to process your claim from cash register receipts. ➤ Please include your signature at the bottom of the form and mail to the address on the right. ➤ You may print more copies of this form at www.healthnet.com. 	<p>Health Net of the Northeast Attn: Pharmacy Management P.O. Box 904 Shelton, CT 06484</p>

MEMBER INFORMATION			
Member ID#:	Member Last Name:	First Name:	Date of Birth:
Street Address:	City:	State:	Zip Code:

**ATTACH YOUR ITEMIZED PHARMACY RECEIPTS.
If You Do Not Have Your Itemized Receipts, Please Ask Your Pharmacist To Complete And Sign This Section.**

Attach Receipts Here:

Rx Number:	Date Filled:	Quantity:	Days Supply:	Rx Price:
Medication Name and Strength:			NDC Number:	
Pharmacy Name:			Telephone #:	NABP #:
Street Address:		City:	State:	Zip Code:

PHARMACIST: For a compounded prescription claim, please use the fields below to list each ingredient.

NDC Number:	Drug Ingredients:	Quantity:
Pharmacist's Signature:		Date:

I certify that the above information is correct and that the above person is eligible for benefits. I have received the medication described herein and authorize release of all information contained on this form to Health Net or its agent.

I agree that any benefits payable hereunder for prescription drugs are not assignable and that any assignments or attempting assignment thereof shall be void. I further represent that there has been no assignment of benefits hereunder. Signature is required or rejection will occur.

Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading information concerning any material fact thereto, commits a fraudulent insurance act.

New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed \$5000 and the stated value of the claim for each such violation.

Member / Subscriber Signature:	Date:
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